Though most of the contacts between village people and the office-bearers arise out of official roles, the local priest, the assistant medical officer in charge of the Sasembata mission hospital, the mission teachers, the council's sanitary officer and others who lived near Sivepe, or temporarily stayed near Sivepe, tended to have at least one or two families with whom they were on mutual visiting terms and who regarded them as personal friends. At the same time, their relationship with many of the other Sivepe families remained definitely formal.

Contacts occurred almost always either in Sivepe or in a village nearby, on the initiative of the office-bearer (if the contact was official). Formal visits by councillors, sanitary inspector, coffee factory officers occurred about once monthly. Contacts with Church personnel occurred almost daily at the mission station, though formal calls by the priest or a teacher to Sivepe were made perhaps once a month, usually in connection with some quarrel that had arisen. The village was most active in its contacts with the mission hospital, several patients presenting themselves daily with minor ailments. Serious cases were often referred to Saiho hospital and most of the referred cases actually went to Saiho. There was a monthly visit from nurses dealing with infant health and expectant mothers; most of the mothers took their babies to be checked and weighed and no objections were made to preventive injections.

There were no cases, in Sivepe, of inter-marriage between local people and Papuans occupying these specialized roles, but in Inonda one man married the mission teacher's daughter. Otherwise, contacts of the type described in this section were sparser in Inonda, as the mission and medical establishment was at Hohota, three miles away, and on a far smaller scale. Inonda did have some direct contact with government over agricultural matters as one man expressed interest in entering an experimental scheme for growing beef cattle. He has adquate land and education, but the scheme had not gone beyond initial discussions by the time I left. Finally, Inonda had an arrangement with a Papuan who was a distant affine and who had a truck with which he took garden produce weekly from Inonda to the Embi hospital. The village people paid this man for his cartage. No comparable arrangement existed in Sivepe. Finally, contact with the officers of the Local Government Council seemed to me less frequent in Inonda than in Sivepe and to generate much less interest. This was no doubt due to rivalries between the village leader and the councillor, but also to a less keen interest in council objectives on the part of the majority of families.

The contacts described in this section, unlike the ones discussed earlier, do not characteristically occur in a kinship context. Hence, the contacts do not necessarily occur equally with all categories of members of the community, but when the problems have to do with land or politics or the conduct of village affairs, the married men are principally concerned; in educational matters

Section 3: Social Services: Health Assistance

657 Social services were provided partly by the government, partly by the council and partly by the mission. The services provided by the different organisations were so tightly interlinked and so systematically complemented one another that it will be convenient to present, in the present chapter, the overall system that was operating. This system was a product of government planning, while council and mission made specific contributions in their special areas of competence. In the next chapter, I shall look at these services again, from the viewpoint of general mission objectives.

657 In this interlocking of services, it was the government which met the bulk of the expenditure, as Table 13 clearly shows. On the 743 other hand, over Papua as a whole 60% of the hospitals were conducted by the missions and over one quarter of the aid posts. In the year 1964-1965, in the Northern District, the three administration hospitals had 3,671 admissions and 13,176 out-patients while the corresponding number for mission institutions was 3,286 admissions, 255,460 out-patients. It is therefore clear that the mission contribution to health services in the Territory is, in terms of patients treated, far greater than its budgetary contribution (2% of total expenditure on public health) would suggest. This disproportion is only slightly lessened if we consider the value of grants-in-aid and drugs supplied by the government to mission hospitals. Clearly, it costs a great deal less to treat a patient in a mission than in a government hospital.

743 The Saiho Hospital, which served all Orokaiva territory, was a sprawling settlement of a great many buildings, almost all made of [344] native materials. Only one building, as far as I remember, was in Australian style, with weatherboard walls; this contained the doctor's office, some other administrative offices, and was used for the few non-Papuan out-patients who occasionally called. The wards were all built of bush materials. Although the statistics show 2,500 admissions and 5,000 out-patients per year, there was only one physician at the hospital who at the same time functioned as superintendent and had a heavy administrative burden. He had a small expatriate administrative staff, and a few expatriate nurses. In the beginning of 1967, a second physician, a Papuan woman, joined the staff. The superintendent was also in charge of the training of aid post orderlies. Increasingly, Papuan nurses, trained in a three-year course at Port Moresby, are being used. A substantial number of hospital orderlies are employed.

758 It is not the policy of the hospital to offer ambulance services, 743 so that the village people are expected to make stretchers out of bush materials and carry in their sick. In practise, hospital and administration vehicles will frequently carry sick people to hospital and I have never actually seen the stretchers made. People would certainly know how to do it. Upon arrival, the sick person is interviewed by a hospital orderly; usually he is accompanied by a number of

A [See Cat. 116, p. 218--Analyst]

758 relatives who answer questions if he is too sick. The orderly speaks
743 the Orokaiva language; the interview gives most of the information an examining physician would require, so that the language barrier between the patient and the Australian physician poses no essential problem. Orderlies can, in any case, act as interpreters. This interview is conducted without much delay and the physician is usually able to see patients fairly promptly. The relatives meanwhile stay around to hear the news; sometimes they leave the patient and go back to their village, but often they stay around the hospital as long as the patient is there.

The hospital does not normally supply patients' food. This simplifies the operation; the patients' diet will in any case consist almost solely of taro. There is usually a relative around Saiho who will cook and take food to a patient. While this may seem an unduly casual procedure, it is valuable in relieving the tension of the patient as well as the relatives. If the complaint diagnosed by the physician requires major surgery or the attention of a specialist, the patient is flown to Port Moresby at government expense. I have seen this done several times and always rather promptly. The Port Moresby hospital is a modern well-equipped institution. Admission to hospital is free to Papuans.

A minor racial upset resulted from the circumstance that the medical officer in charge of the Northern District was a Papuan whereas the superintendent of the hospital was an Australian. It arose because the expatriates, objecting to being treated by a Papuan physician, insisted upon being attended by the superintendent. The latter, placing professional esprit de corps above expatriate solidarity, would not allow the medical officer to be bypassed much to the chagrin of the planters (the public servants and missionaries did not seem to be too troubled). In an earlier chapter, I have commented on the unusually good relations between the superintendent and the Papuans.

Though Sivepe depended on the Saiho hospital for serious illness, minor accidents, malaria, dysentery, various other stomach ailments, skin troubles, etc. were treated at the small mission hospital in Sasembata. This hospital was lucky to have a competent assistant medical officer in charge in 1966. In earlier days, just after the eruption, the hospital was conducted by an Australian nurse and it was only since 1965 that Papuan assistant medical officers began to graduate and to be available for work in places such as Sasembata. I have already mentioned that the people were genuinely pleased at the improvement in service and expressed their pleasure by building a new hospital. This was constructed out of bush materials, contained about 12 beds also made of bush materials, and was equipped with a small selection of basic drugs supplied by Saiho hospital.

Whereas Saiho hospital was conducted by the government, Sasembata hospital was a mission responsibility. The Sasembata staff was paid at mission rates, far lower than the government rates. For instance, the assistant medical officer received $11 per month, whereas the

758 743 government scale in 1965 was $1000-$1800, per annum. The orderlies assisting the AMO received $1 per month. This did not necessarily mean that the AMO lacked the qualifications to get a government job; he could easily have obtained one.

Every day some dozens of people would present themselves with minor and sometimes major ailments. They would be bandaged, given a pill or some other simple treatment. Very sick cases were referred to the hospital; most days, a car would come to the mission station and the AMO could get transport for his patients. The beds were occupied for the more serious cases who could not well go home but who did not need the more specialised treatment of Saiho. The nursing aid never stayed in the hospital overnight but one or two relatives of the patient usually did; if the patient's condition deteriorated, the AMO could always be called over as he lived on the mission station. (See Map XI.)A

743 [344] Inonda was served by one of the medical aid posts which are being built all over the district. This was at Hohota, next to the mission school. Such aid posts are built of milled timber and paid for by the Higaturu Council; the government may subsidize these posts. The salary of the aid post orderlies, who work on a part time basis, is paid by the Council also, but in 1966, the government paid a 50% subsidy on these. Most of the large resettlement villages (Hohorita, Koipa, Kiorota, etc.) had them, or were getting them, three posts being added in the year 1966. The smaller villages had to share aid posts; thus, there were no plans to build one at Inonda, and people were expected to walk the three miles to Hohota for treatment.

758 743 The standard of aid was not always as high at these posts as it was in Sasembata. Hohorita had much trouble replacing an orderly who had left. Inonda found it difficult to get service; on one occasion when we went to the aid post, we heard, upon arrival that the orderly had just gone to town for the day. On another occasion, he was in his house; he had been hunting, was tired and would not see anybody. This would have been a rare occurrence indeed at Sasembata. The orderlies regarded themselves as part-time employees who chose their own working hours. This would have been reasonable (for average cases) were it not for the distance between Inonda and Hohota. How often will a man walk six miles to collect a single malaria pill? A more serious problem is that the orderlies are not nearly as well trained as the AMO; hence, they can hardly be expected to carry out diagnosis.

755 People were greatly taken with the medical services available; they were not a replacement but an addition to traditional magical practises. When my interpreter was sick he was very pleased to swallow the pills I gave him, but his house was full nonetheless with numerous herbs collected for his complaint and these were being boiled in a pot or otherwise ingested simultaneously with my medicine. The Orokaiva view is that medicine, given for the purpose of curing, will be effective if it is stronger than the sorcerer causing the illness. It has been noticed that this is sometimes the case with Western

A [See Cat. 116, p. End Map 10--Analyst]

## CHAPTER VI: Addition and Loss of Community Members

161 Though the population of Sivepe has increased between the years 1951 and 1967, this increase is less than might have been expected after the settling in Sivepe of two additional Jegase families and [166] six Sorovi households. An analysis of Table 16 will show that the net population increase in 16 years corresponds very closely to the increase due to the immigration of 15 Jegase and 26 Sorovi people into Sivepe. The 1951 figures showed 40 children who, today, should range between the ages of 17 to 35; 15 of these were boys. Looking at the present Sivepe population, we find only six men of that age group and only three of these were children in Sivepe in 1951 (the other three are immigrants). This depletion of the 17-35 year age group is one of the most striking features of the present population structure.

The second striking change is in the number of children--there are almost twice as many of them in Sivepe today as there were in 1951. [158] It seems likely that this increase should in part at least be due to [165] the improved health services: the monthly clinics, with the possibility of immediate referral of young children to the Saiho hospital, do save 167 a number of lives, even if the mortality rate is still high.

166 The migration of young women into and out of Sivepe is a continuous process due to virilocal residence; a far more significant [591] demographic process is the outflow of men as a result of labour migration. [464] Rimoldi reported that ten male siblings and sons of householders of his (Jegase-Timumu) sample were employed outside Sivepe in 1962; in 1966, I found that this figure had risen to 12. I have only included men who had been residents of Sivepe and who had left, as adults, to find work. By this criterion, it would not be possible to class absent brothers and sons of Sorovi men as "labour migrants from Sivepe," as these men had never lived in Sivepe at any time but had [614] been residents of Garumbi before they became labour migrants. There [177] were, at the time of the survey, no labour migrants of the Seho clan. The fact that Jegase had many labour migrants while Seho had not even one certainly accentuated the relative dearth of contact with the outside world that characterised Seho. On the other hand, we should not read too much significance into it. It so happened that the Seho men came from very small families; most of them actually had no adult brothers living, and though they had many children, the only adult children they had happened to be girls. Thus they collected a disproportionate amount of bridewealth but could not contribute much to the external labour market. The Seho men were not actually as cut off from the world as these statistics might suggest: all had sisters' sons and sisters' husbands, real or classificatory, who were labour migrants; two had themselves been labour migrants earlier in life. In

A [See Cat. 116, p. 225--Analyst]

628 I found them elsewhere among the Orokaiva, it naturally became no easier for the mission station to lead the village.

758 759 During the time I was at Hohorita, there was no local medical service because the officer appointed by the Health Department was a Sangara who insisted that a house should be built for him before he arrived. (Orokaiva are bound by law to do such work, in payment for [653] government services rendered.) His kinsmen at Hohorita thought that if he wanted a house, he should build it himself. The medical, however, was in no hurry at all to go home; he stayed at his previous post for almost a year after he should have been transferred. Hohorita complained to the Health authorities that they had no medical; they found that unless they built the house, no medical would be provided but they would have to go to Saiho for service. Finally they yielded. This was far from being a case of anomie: it was a battle about the status to be granted to public officials at Hohorita.

653 In Sivepe, nobody would have questioned this status; they would have built a house at once for any public official who would have wanted to live there. But then, such a person would be bound to be a stranger, not a person "like themselves." When a village has produced a dozen or so public officials of one sort or another, the question begins to look different: what is so special about these people that we have to build houses for them? Furthermore, once upon a time, the Sangara working timetable was rather flexible, but with cashcropping on the Hohorita scale, and long walking distances between home and work, the Hohorita people were rather busy earning money from coffee. Time had become an economic resource.

This was a frequent subject of mild argument between me and the other expatriates. The expatriates used to complain that the Orokaiva were no longer willing to do any work (i.e., perform free services such as I am now discussing). They thought that if the Orokaiva were to advance economically, they would need to work much harder. I used to tease the other expatriates by saying that this growing reluctance to do free work for the government (roads, houses for officials, etc.) was evidence for the success of the economic development policy the expatriates claimed to be promoting. They thought this to be a sick joke.

173 In an earlier chapter, I already referred to an unusual foreshortening of Orokaiva history practised by Sangara informants of today. It is certainly remarkable that, according to Sangara, the Orokaiva only began to make feasts <u>after</u> the time of European contact, because earlier they could not grow enough food to hold them. Statements of this sort were made in two places (Sombou, Hohorita) by elders sitting together in groups and instructing me. I have already explained how such statements fit the traditional <u>structure</u> of Orokaiva history: original time / culture established by culture heroes / present day. As the coming of the Europeans occurred more than two generations ago, this event would seem to have been confused with the coming of the [731] culture heroes. When I did, in a very innocent way, express my